Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Hill a prisoner at HMP Oakwood on 24 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Hill died on 24 May 2018 of heart disease and amitriptyline poisoning at HMP Oakwood. He was 61 years old. I offer my condolences to Mr Hill's family and friends.

Mr Hill's clinical care was below the standard that he could have expected to receive in the community. There were several serious shortcomings, the most significant being that insufficient consideration was given to the possibility that Mr Hill's symptoms of illness might be due to amitriptyline toxicity, and there was a long delay in analysing and acting on an electrocardiogram taken on the morning of his death. An outstanding cardiology referral had not been fully explored and staff did not follow national guidelines relating to monitoring and investigating high blood pressure readings.

I am satisfied that the resuscitation attempts were timely and proficient when Mr Hill was found unresponsive. However, control room staff did not call an ambulance immediately when a medical emergency code was called.

I am concerned that yet again, staff authorising security risk assessments for a hospital visit took insufficient account of the effects of failing health and reduced mobility on current risk and Mr Hill was restrained without a medical opinion, or appropriate justification. This issue has been raised with Oakwood many times before and with the Head of Operational Contracts at HM Prison and Probation Service. The Director must take urgent steps to ensure that staff adhere to the legal requirements when escorting prisoners who need hospital treatment.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **May 2019**

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Summary

Events

1. On 20 October 2016, Mr John Hill was convicted of sexual offences and remanded to HMP Hewell. He was sentenced to five and a half years in prison. Mr Hill had a history of substance misuse, reduced mobility due to a longstanding back injury and an outstanding cardiology referral to investigate high blood pressure and fainting.

2. On 30 August 2017, Mr Hill transferred to HMP Oakwood. His blood pressure was elevated and several later readings were also abnormal.

3. Mr Hill initially received ibuprofen and paracetamol to relieve his chronic back pain. However, this was not effective. From 2 October, he was prescribed amitriptyline (an antidepressant also used for pain relief). On 14 December, the dosage was increased from 50mgs to 100mgs.

4. Mr Hill's health declined and he developed several serious symptoms, including frequent falls, double incontinence, urine retention, with persistent and acute confusion. On 10 April, a prison GP and hospital doctors diagnosed a urinary tract infection. On 16 April, the GP stopped Mr Hill's amitriptyline, as he suspected it might be contributing to his confusion. On 19 April, Mr Hill resumed amitriptyline at a lower dose of 25mgs, increased to 75mgs on 4 May. He continued to take this medication until his death.

5. On 20 April, another prison GP completed an urgent referral to a colorectal specialist (under the NHS pathway for suspected cancer) after Mr Hill had reported blood in his stools. Mr Hill later refused to go to the hospital appointments arranged to investigate this.

6. Early morning on 24 May, Mr Hill had chest pains. A nurse examined him and found no obvious symptoms of a heart attack. He requested an electrocardiogram (ECG) to test Mr Hill's heart activity and stood down the ambulance that had been called. At 11.30am, wing staff called a code blue emergency after finding Mr Hill unresponsive in his cell. Resuscitation attempts were unsuccessful and the prison's paramedic confirmed his death at 11.55am.

Findings

7. The clinical review found several serious shortcomings in Mr Hill's clinical management and we agree with her conclusion that the standard of care was below that which he could have expected to receive in the community.

8. Healthcare staff at Hewell initially attempted to find out about Mr Hill's outstanding cardiology referral, but they did not record the outcome or consider a fresh referral. This was a missed opportunity for specialist investigation of a potentially significant medical condition.

9. Healthcare staff assumed that Mr Hill's acute confusion was due to a urinary tract infection without testing his urine, and consideration was belatedly given to the possibility that it was due to the toxicity from amitriptyline.

10. The ECG taken on the morning of Mr Hill's death was not immediately reviewed, as it should have been. When interpreted after his death, it showed abnormalities that would have required urgent hospital investigation.

11. When Mr Hill arrived at Oakwood his blood pressure was raised and there were further abnormal readings over the following months. Oakwood had no blood pressure pathway and no arrangements were made to monitor or investigate his high blood pressure.

12. There was a delay of ten days in processing the urgent referral for suspected cancer. Although this was unrelated to Mr Hill's death, this was another example of the failure to follow expected standards and provide optimum care at Oakwood.

13. The resuscitation process was timely and professional. However, there was a delay of three minutes in requesting an ambulance when the code blue emergency was called.

14. The risk assessment for Mr Hill's emergency hospital visit on 16 April contained no medical information, or any justification for the use of handcuffs. Therefore, we are not satisfied that it fully reflected the impact of Mr Hill's poor mobility and illness on his risk at the time of the visit.

Recommendations

- The Head of Healthcare at HMP Hewell should ensure that outstanding hospital referrals for newly-arrived prisoners are followed up appropriately and the outcome documented.
- The Head of Healthcare at Oakwood should ensure that staff monitor and record blood pressure readings and create care plans for all prisoners with hypertension, in line with national guidelines.
- The Head of Healthcare should ensure that clinicians are aware of best practice in prescribing amitriptyline and investigate all likely causes of a prisoner's symptoms of ill health, including the side effects of medication.
- The Head of Healthcare should ensure that there is an auditable process to track requests for clinical investigations and the results.
- The Head of Healthcare should ensure that there is an auditable process for reviewing non-routine ECG readings within ten minutes, when a prisoner reports chest pains.
- The Head of Healthcare should ensure that clinicians are aware of symptoms to be reported to the GP and that urgent referrals to specialists are processed within 24 hours.
- The Director should ensure that control room staff request an ambulance immediately when a medical emergency response code is called.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the

use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

- The Director should revise the prison's escort risk assessment form to ensure that it requires:
  - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
  - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk,

  and should send the Ombudsman a copy of the revised form.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Hill's prison and medical records.

17. NHS England commissioned a clinical reviewer to review Mr Hill's clinical care at the prison.

18. The investigator and clinical reviewer jointly interviewed five members of staff at HMP Oakwood on 24 July 2018.

19. We informed HM Coroner for South Staffordshire District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. The investigator contacted Mr Hill's sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. His sister was concerned that Mr Hill had been left alone on 24 May, after requiring healthcare assistance earlier in the morning.

21. Mr Hill's sister received a copy of the initial report. She made no comments.

22. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies.

Background Information

HMP Oakwood

23. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

24. Oakwood is made up of several house blocks which are subdivided into wings. The main residential blocks have eight wings: A-D upper and A-D lower. Mr Hill was located on Cedar House Block B, upper wing, on the lower landing.

HM Inspectorate of Prisons

25. The last inspection of HMP Oakwood was conducted in February and March 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2018, the IMB reported that a Learning from Experience Group had been set up to review recommendations from clinical reviews, PPO investigations and Coroners. The group highlighted themes and shared learning. The Board had some concerns about the number of staff vacancies in the healthcare department.

Previous deaths at HMP Oakwood

27. Mr Hill was the 19th prisoner to die at Oakwood since January 2016 and the 16th to die from natural causes. There have been three subsequent deaths.

28. We have made previous recommendations to Oakwood about the management of long-term health conditions, emergency response procedures and the use of restraints.

Key Events

29. On 20 October 2016, Mr John Hill was convicted of sexual offences and remanded to HMP Hewell. The next day, he was sentenced to five and a half years imprisonment.

30. At his initial health screen, a nurse recorded that Mr Hill had a history of substance misuse and had taken heroin and crack cocaine that day. He had poor mobility (due to spinal surgery) and walked with a stick. He told the nurse that he was due to see a cardiology specialist at a hospital and the prison wrote to the hospital to query this. (His community records showed that his GP had sent a referral to the hospital to investigate high blood pressure and fainting.)

31. A prison GP then reviewed Mr Hill's notes and prescribed methadone stabilisation. Over the next few months, most of Mr Hill's medical appointments related to methadone detoxification, falls and sessions to stop smoking.

32. On 30 August 2017, Mr Hill was transferred to HMP Oakwood. At a health screen, a nurse noted his ongoing back pain and a reading indicating that his blood pressure was raised. Mr Hill was prescribed pain killers (ibuprofen and paracetamol).

33. On 5 September, a nurse assessed Mr Hill as he had requested stronger painkillers (tramadol, an opiate-based drug, and diazepam). A prison GP reviewed this request the next day, but re-prescribed the previous painkillers.

34. On 12 September, a nurse examined Mr Hill. They discussed his back injury, which had happened ten years before and had resulted in the removal of two discs and damage to his spinal cord. She explained that, given his opioid addiction, it was doubtful that the GP would prescribe opiate-based medication and Mr Hill said he understood this. She referred him to the physiotherapist for long term management and to the GP for review of his pain relief. She also asked for him to be moved from the workshops to alternative suitable employment, as he was a wheelchair user who could only walk short distances and was unable to stand for long periods.

35. A prison GP reviewed Mr Hill on 2 October. He noted chronic back pain which was not controlled and prescribed amitriptyline 50mgs daily (an antidepressant that is also used to relieve chronic neuropathic pain); naproxen (an anti-inflammatory painkiller); and omeprazole (to reduce stomach acid).

36. Mr Hill began physiotherapy on 9 October and had regular reviews. On 11 October, a safer custody officer noted that an occupational therapist had assessed him and the prison had arranged for aids to support his mobility.

37. On 14 December, a prison GP increased the prescription of amitriptyline to 100mgs daily, as a nurse had told him that Mr Hill was feeling breakthrough pain by midday.

38. Mr Hill had several falls at Oakwood, witnessed by his cellmate, who said that he would lose consciousness during these episodes. On 3 February 2018, Mr Hill's

personal officer noted that he seemed to be struggling with his health and moving around the wing.

39. On 14 February, at an appointment to review Mr Hill's pain relief, a nurse recorded that the amitriptyline and naproxen were not controlling his pain. A few days later, his physiotherapist noted that his back pains were the same. She planned a further review in eight weeks and to refer him to the pain management team if his carer could not operate a TENS unit (a pain relief machine, which uses a mild electrical current).

40. On 24 February, Mr Hill said he had fallen during the night. Healthcare staff examined him, completed a falls assessment and took his blood pressure (which was raised). After dizzy spells and another fall on 27 February, a nurse and the prison's paramedic examined him. They requested blood tests and performed an electrocardiogram (ECG - a test to check the heart's rhythm and electrical activity), which a prison paramedic checked and found to be normal. They advised him to contact wing officer, or press his cell bell at night if he experienced any pain or new symptoms.

41. On 1 March, wing staff noted that Mr Hill was taking longer than normal to get over his fall the previous week. Further entries in March, indicated that his health was deteriorating. He was unstable on his feet, had further falls and used his wheelchair more. A nurse completed a falls assessment on 21 March. Mr Hill also had diarrhoea and vomiting over two to three weeks.

42. In the early hours of 10 April, Mr Hill fell out of bed. Later that morning, a prison paramedic examined him and found him confused. A prison GP reviewed Mr Hill in the afternoon and noted acute confusion. He thought Mr Hill might have a urinary tract infection and prescribed antibiotics. He also requested blood tests for possible shingles.

43. During the evening, wing staff called a code blue emergency (which indicates that a prisoner is unconscious or has difficulty breathing) as Mr Hill had been found slumped in a chair and was unresponsive for two minutes. When he regained consciousness, he was still confused and reported chest and abdominal pains. A nurse examined him and noted he had both a raised pulse and blood pressure. She sent him as an emergency to hospital in Wolverhampton. Doctors diagnosed urinary tract infection and discharged him later that night.

44. On 12 April, Mr Hill had another fall. Healthcare staff recorded that he remained confused and disoriented and they felt this was linked to his infection.

45. Mr Hill's personal records show that on 13 April, he fell four times. On the first occasion, staff called a code blue. It was noted that the infection was affecting his general wellbeing, his memory had deteriorated and there had been episodes of double incontinence. Healthcare staff reviewed him several times during the day and found his pulse and blood pressure raised. Wing staff increased monitoring from hourly to half hourly. Mr Hill remained unwell, receiving frequent medical reviews and a nurse noted serious concerns about him.

46. On 16 April, a prison GP stopped Mr Hill's amitriptyline, as he thought it might be contributing to his confusion. On the same day, a prison social worker completed

an emergency care assessment and arranged for social care three times a day, which began immediately (and ended on 27 April).

47. On 17 April, a prison GP prescribed a stronger course of antibiotics. A blood pressure reading that day was recorded as raised.

48. By 19 April, Mr Hill was significantly better. A nurse noted it had been agreed to restart his amitriptyline, initially at a lower dose (25mgs) to assess whether his confusion returned. If not, it could be increased. (It was increased to 75mgs daily on 4 May.)

49. On 20 April, a GP reviewed Mr Hill, who had reported blood in his stools. (He had mentioned this a few days earlier, but healthcare staff had attributed it to a side effect of antibiotics.) He referred him urgently to a colorectal specialist, under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. During a subsequent consultation on 30 April, a prison GP noted that the hospital referral requested on 20 April had been despatched that day.

50. On 18 May, Mr Hill refused to attend hospital for a colonoscopy (examination of the large bowel with a camera). The escort officers reminded him of the importance of attending, but he would not go and signed a disclaimer to this effect. The appointment was rebooked for 22 May. Mr Hill again refused to attend, but there was no evidence that healthcare staff were aware of this.

51. On 24 May, Mr Hill felt chest pains at 5.00am, but did not tell wing staff until 7.45am. An officer called a code blue immediately. A nurse examined him and found that his observations were normal, with no sweatiness, clamminess, or shortness of breath, so he asked for the ambulance to be stood down.

52. A nurse asked a healthcare assistant to conduct an ECG and he completed this just after 8.30am. However, due to attending a code blue for another prisoner and running clinics, the nurse did not ask a prison paramedic to interpret the reading until approximately 11.00am. The prison paramedic went to the houseblock at around 11.15am, but he did not receive the ECG print until after Mr Hill's death. The result was abnormal and a prison paramedic said he would have sent Mr Hill to hospital if he had seen it at the time.

53. At 11.30am, wing staff went to check on Mr Hill in his cell and found him unresponsive. An officer called a code blue and started chest compressions with another officer. A prison paramedic arrived at 11.32am, followed by a nurse. They applied a defibrillator, which went through three cycles and advised no shock. The prison paramedic then conducted full advanced life support.

54. Ambulance paramedics arrived at the prison at 11.48am and reached the cell at 11.52am. They did not attempt resuscitation and the prison paramedic confirmed Mr Hill's death at 11.55am.

Contact with Mr Hill's family

55. Shortly after Mr Hill's death, a prison manager and an officer were appointed as the prison's family liaison officers. Just after 3.00pm, they visited Mr Hill's sister. They informed her of Mr Hill's death and offered their condolences and support. In the following days, they provided information about the processes to be followed and offered the opportunity for Mr Hill's sister to visit his cell. In line with national policy, the prison contributed to the cost of Mr Hill's funeral.

Support for prisoners and staff

56. A senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support and the services of the care team.

57. The prison posted notices informing other prisoners of Mr Hill's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm, in case they had been adversely affected by Mr Hill's death.

Post-mortem report

58. The report of the post-mortem examination concluded that Mr Hill's death was due to ischaemic heart disease and amitriptyline (and metabolite) poisoning.

59. The pathologist noted:

> "*Toxicology shows a high level of amitriptyline (0.78mg/L) and its metabolite nortriptyline (0.38mg/L). This exceeds therapeutic levels but is lower than the usual fatal concentration (usually above 2mg/L). However amitriptyline is cardiotoxic causing fatal arrhythmias in overdose and it is noted that the deceased already had significant ischaemic heart disease and this may well enhance the cardio toxic effect*."

Findings

Clinical care

60. Mr Hill arrived at Hewell with a longstanding back injury which caused chronic pain and affected his mobility. He also had an outstanding cardiology referral to investigate high blood pressure and fainting.

61. When Mr Hill moved to Oakwood, his back problems and raised blood pressure continued. Between October 2017 and his death (except for three days in April), Mr Hill was prescribed amitriptyline for his pain.

62. The clinical reviewer concluded that Mr Hill's care at Oakwood was not the equivalent of that he could have expected in the community. We agree that there were several serious shortcomings and we discuss the key issues below.

Monitoring of Mr Hill's blood pressure

63. Staff at Hewell wrote to a hospital about Mr Hill's cardiology referral, but there is no record of either a response, or follow up to the original query, or consideration of a re-referral to the hospital. Given the episodes of high blood pressure and the cause of Mr Hill's death, this was a missed opportunity for specialist intervention.

64. A blood pressure reading taken during Mr Hill's initial health screen at Oakwood, showed his blood pressure as raised. No action was taken to monitor this. Several subsequent blood pressure readings were also abnormal, but there is no evidence that staff looked for any patterns in the readings, or took steps to monitor or investigate this. Oakwood had no blood pressure care pathway. The Head of Healthcare said that raised blood pressure is common in newly-arrived prisoners so he would have expected a further check a couple of days later.

65. If untreated, high blood pressure increases the risks of problems such as heart attacks and strokes. The National Institute for Health and Clinical Excellence (NICE) guidelines on the management of hypertension indicate the importance of regular monitoring and recording of blood pressure in hypertensive patients. Healthcare staff should have followed these guidelines. We make the following recommendations:

The Head of Healthcare at HMP Hewell should ensure that outstanding hospital referrals for newly-arrived prisoners are followed up appropriately and the outcome documented.

The Head of Healthcare should ensure that staff monitor and record blood pressure readings and create care plans for all prisoners with hypertension, in line with national guidelines.

Prescription of amitriptyline

66. At Oakwood, doctors initially prescribed ibuprofen and paracetamol for Mr Hill's back pain. However, as this was not controlling his pain effectively, a prison GP began prescribing amitriptyline 50mgs daily, on 2 October 2017, which he doubled to 100mgs on 14 December. Medical records showed that in February

2018, around ten weeks after this increased dose, Mr Hill developed several problems, including dizzy spells and falls; elevated blood pressure and pulse; diarrhoea and vomiting; acute confusion; periods of dehydration and urine retention; fine tremors; and double incontinence. Due to his frailty, he required a full social care package.

67. The clinical reviewer noted:

"Common side effects of amitriptyline, as listed in the BNF [British National Formulary], are fatigue, dizziness, high blood pressure, water retention, palpitations, nausea and diarrhoea. Sometimes a tremor can develop. Symptoms of overdose of amitriptyline can include dry mouth, heart dysfunction and urine retention."

68. A prison GP thought Mr Hill's confusion might be due to a urinary tract infection and hospital doctors came to the same conclusion. However, he subsequently considered that the amitriptyline might be contributing to Mr Hill's acute confusion, so he stopped prescribing it on 16 April. BNF guidance indicates that amitriptyline should be gradually reduced over a minimum period of four weeks, to prevent withdrawal symptoms, but the clinical reviewer was satisfied that stopping it immediately was justified in Mr Hill's case given the concerns about toxicity.

69. On 19 April, a nurse re-prescribed amitriptyline at a lower dose of 25mgs, as Mr Hill's symptoms had improved. She noted that it could be increased if his confusion did not return. This was increased to 75mgs on 4 May and he remained on this dose until his death.

70. The clinical reviewer found that the diagnosis of urinary tract infection was not substantiated by a urine test, although urine tests had been requested. Mr Hill could not pass urine for long periods, but this did not trigger any further investigation. There was no process to track or audit requests for tests and the results.

71. Mr Hill had most of the side effects listed in the BNF. We agree with the clinical reviewer's concerns about the assumption of an infection without appropriate testing and we are very concerned about the failure to consider the possible toxic effects of amitriptyline sooner. We make the following recommendations:

The Head of Healthcare should ensure that clinicians are aware of best practice in prescribing amitriptyline and investigate all likely causes of a prisoner's symptoms of ill health, including the side effects of medication.

The Head of Healthcare should ensure that there is an auditable process to track requests for clinical investigations and the results.

Examination of Mr Hill's chest pains and reviewing ECGs

72. When Mr Hill reported chest pains on the morning of 24 May, a nurse conducted a prompt and thorough investigation. He asked for the ambulance that had been called in response to the code blue to be stood down as the symptoms did not appear to be those of a heart attack. He rightly obtained an ECG, but did not ask for it to be interpreted until over two hours after it was taken. The prison

paramedic reviewed the ECG result after Mr Hill's death and it showed an abnormality.

73. West Midlands Ambulance Service made a complaint to the prison, as the external paramedic who had attended the emergency on 24 May was uneasy about the handling of the earlier report of chest pains. The ambulance service was concerned that the delay in interpreting the ECG and providing appropriate care on its findings might have impacted on the clinical outcome for Mr Hill.

74. The Head of Healthcare told us that at the time of Mr Hill's death, Oakwood had an ECG pathway that had been put in place following the investigation of a previous death. However, staff had not followed it on that day. This is a cause for serious concern. We make the following recommendation:

The Head of Healthcare should ensure that there is an auditable process for reviewing non-routine ECG readings within ten minutes, when a prisoner reports chest pains.

Referral for suspected cancer

75. On 15 April, healthcare staff regarded blood in Mr Hill's stools as a side effect of antibiotics. The clinical reviewer indicated that this was not correct and this symptom should always be reported to a GP. On 20 April, Mr Hill told a prison GP himself. The doctor immediately completed an urgent referral to a specialist, but this was not despatched by prison staff until 30 April.

76. Mr Hill twice declined to attend the resulting hospital appointments. Although escort staff tried to encourage him, there was no indication that healthcare staff spoke to him to discuss the potential medical consequences and it seems that they were not even told the second time he refused.

77. The delay in sending the referral to hospital was not linked to the cause of Mr Hill's death, but this is another example of poor practice. We share the clinical reviewer's view that the prison must improve their practice in assisting early detection of cancer. We make the following recommendation:

The Head of Healthcare should ensure that clinicians are aware of symptoms to be reported to the GP and that urgent referrals to specialists are processed within 24 hours.

Emergency response

78. Prison Service Instruction (PSI) 3/2013 *Medical Emergency Response Codes* requires prisons to use a code system in emergencies, to ensure that an ambulance is called immediately in a life-threatening medical emergency and to enable staff to bring equipment relevant to the nature of the emergency.

79. When staff found Mr Hill unresponsive on 24 May, they called a code blue emergency at 11.30am. The resuscitation process was prompt and efficient. However, ambulance records show that the request for an ambulance was received at 11.33am, not 11.30am as stated on the control room log. While we are satisfied that this delay did not affect the outcome for Mr Hill, in other

emergencies such a delay could be critical. We make the following recommendation:

The Director should ensure that control room staff request an ambulance immediately when a medical emergency response code is called.

Security risk assessment and use of restraints for hospital appointment

80. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

81. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.

82. The emergency escort risk assessment for Mr Hill's journey to hospital on 10 April stated that he was a medium risk to the public and a low risk on all the other security factors, including the risk of escape and likelihood of outside assistance. There was no medical input on the form. The risk assessment concluded that he should be escorted by two prison officers and restrained using single handcuffs/escort chain, which were not to be removed for emergencies or medical treatment. They could be removed in a life-threatening situation, with prior approval by the duty director.

83. The Prison Service has a duty to protect the public when escorting prisoners outside prison. It also has a responsibility to balance this by treating prisoners with humanity. Mr Hill was a compliant category C prisoner, who was on the enhanced level of the prison's incentives and earned privileges scheme. He had limited mobility, using a stick around his cell and a wheelchair for longer distances. In spite of this and an escort of two officers, the prison concluded that he should be handcuffed, with no justification as to why this was considered necessary.

84. We have made repeated recommendations to Oakwood about restraints, as well as recommendations to the Prison Service's Head of Operational Contracts to try and achieve compliance on this issue. It is very disappointing to have to raise this again.

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Director should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk,**

and should send the Ombudsman a copy of the revised form.

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